## Idaho Department of Health and Welfare ELIGIBILITY APPLICATION FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

Region Field Office	
Date Received	

	Data of Dinth
Name	Date of Birth
	SSN
<del>_</del>	Telephone
Defermal Course if other than and	<u>e</u>
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Nome of Dhysician	Yes If Yes, Medicaid Number No. \[ \begin{align*} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Name of Physician	Enrolled in Healthy Connections? No Yes
What services are you seeking?	
☐ DD/ISSH Waiver (Tradition☐ Developmental Disabilities A☐ Family Support☐ ICF/MR	al or Self-Directed Community Supports) gencies (DDA)
Service Coordination	
Other (please specify)	
Guardian (if any)	Family (or unpaid advocate)
	Address
	Telephone
	ded to determine eligibility. If it does not accompany this application, indicate be asked for written authorization to release information.
Evaluation Information	Source or Address of Information
Functional Assessment	
Medical/Social History	
Psychological Evaluation (may be requested)	
	nation you feel may be helpful in making a determination of developmental
	disability.
DD Eligibility DD/ISSH Waiver Service Family Support Reason for Denial:	Approved Denied See Eligibility Approved Denied Approved Denied Denied
Signature of Authorized Rep	resentative of the Department: Date

If you are eligible for and will receive Service Coordination and/or DD/ISSH Waiver services, a Plan Developer will assist you to develop a plan of services. If you participate in the Self Directed Community Supports program you will select a Support Broker to assist you to develop a plan of services.